DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 10/03/10

PRINTED: 08/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445373	A. BUILDING _____ B. WING _____	08/19/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHSIDE HEALTH CARE CENTER	202 EAST MTCS ROAD MURFREESBORO, TN 37130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During the complaint investigation number 26219, 26290, conducted on August 19, 2010, at Northside Healthcare Center, no deficiencies were cited in relation to the complaint under chapter 42 CFR PART 483.13, Requirements for Long Term Care.	F 000		
F 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of	F 203	F 203 SS=D **Description** 483.12(a)(4)-(6) Notice Requirements Before Transfer/ Discharge The facility must put the location to which a resident is to be discharged to in an involuntary discharge letter **Corrective Action** 1. Resident # 11 was not dischargared from the facility. 2. Administrator in-serviced bookkeeping, receptionist and social on required information for an involunary discharge letter on 8/19/10. 3. Involuntary discharge letters will be audited by social and administrator for correct information 4. Findings will be reported to the QA Committee consisting of Medical Director, Administrator, DON, ADON, Risk Managemanet, MDS Coordinator, Medical Records, Social, Activities, Bookkeeping, Payroll, Food Service Supervisor, Maintenance and Environmental Services.	8/19/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cassandra L. Callahan — TITLE: Administrator — (X6) DATE: 9/3/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 203	Continued From page 1 this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on facility's documentation and interview the facility failed to put the location to which a resident was to be discharged to in an involuntary discharge letter for one (#11) of fifteen residents reviewed. The findings included: Resident #11 was admitted to the facility on December 22, 2006, with diagnoses including Multiple Sclerosis, Urinary Tract Infection, and Hypertension. Review of an involuntary discharge letter dated June 1, 2010, revealed no documentation of where the resident would be discharged to.	F 203		

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F 203	Continued From page 2 Interview with the Administrator on August 18, 2010, at 2:30 p.m., in the conference room, confirmed the facility failed to put the location of discharge in the involuntary discharge letter.	F 203		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 278	F 278 SS=D Description 483.20(g) - (j) Assessment Accuracy/ Coordination/ Certified The Assessment will accurately reflect the resident's status Corrective Action 1. Resident #6 MDS was corrected by the MDS coordinator on 09/02/10 to reflect the residents current pressure ulcer status.2. The DON, ADON, MDS Coordinators, and Risk Manager audited the MDS's to ensure they accurately reflected pressure ulcer status on 9/2/10.3. MDS Nurses were inserviced on 9/2/10 by the DON on accurate coding of Pressure ulcer status on the MDS.4. Random MDS audits by the DON, ADON, and Risk Manager on the accuracy of the MDS will be completed weekly for one month and then monthly x 3 to ensure compliance and will report findings to the QA Committee consisting of Medical Director, Administrator, DON, ADON, Risk Managemanet, MDS Coordinator, Medical Records, Social, Activities, Bookkeeping, Payroll, Food Service Supervisor, Maintenance and Environmental Services.	9/2/10

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F 278	Continued From page 3 Based on medical record review, facility document review, and interview, the facility failed to accurately document the skin condition on the Minimum Data Set for one (#6) of fifteen residents reviewed. The findings included: Resident #6 was admitted to the facility on May 9, 2008, with diagnoses including Degenerative Joint Disease, Congestive Heart Failure, History of Pressure Ulcer, and Anemia of Chronic Disease. Review of the Minimum Data Set (MDS) dated May 5, 2010, revealed the resident had a stage two pressure ulcer. Review of the Resident Assessment Protocol dated May 11, 2010, revealed "...No pressure ulcers currently at this time..." Review of the Weekly Skin Assessment revealed the resident had no pressure ulcer after April 14, 2010. Interview with the Director of Nursing (DON), on August 19, 2010, at 7:42 a.m., in the DON's office, confirmed, the resident had no pressure ulcer after April 14, 2010. Further interview confirmed the May 5, 2010, MDS inaccurately identified the resident with a stage two pressure ulcer.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279		

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F 279	Continued From page 4 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, facility document review, and interview, the facility failed to update the care plan for the following: psychotropic medication for one (#6) resident; hospice services for one (#10) resident; and for a wander guard for one (#2) resident of fifteen residents reviewed. The findings included: Resident #6 was admitted to the facility on May 9, 2008, with diagnoses including Degenerative Joint Disease, Depression, and Dementia. Medical record review of the May 1 - 31, 2010, Recapitulation Orders revealed Seroquel (anti-psychotic medication) 25 mg (milligrams)	F 279	F 279 SS=D Description 483.20(d), 483.20(k)(1) Develop Comprehensive Care Plans The facility will update care plans to reflect the resident's current status. Corrective Action 1. a. The care plan for resident #6 has been updated to reflect psychotropic medication by the MDS Coordinator on 8/19/10. b. The care plan for resident # 10 had been updated to reflect hospice care by the MDS Coordinator on 8/19/10. c. The care plan for resident # 2 was updated to reflect the use of a wander guard on 8/19/10 by the MDS Coordinator. 2. MDS Coordinator, DON, ADON, and Risk Management nurse audited the care plans to ensure they reflected the resident's current status. 3. The MDS Coordinator was in-serviced by the DON on 8/19/10 on the care plan accurately reflecting the resident's current status. 4. Random nursing care plan audits by the DON and the ADON on the accuracy of the nursing care plans will be completed weekly for one month and then monthly x 3 to ensure compliance and will report findings to the QA Committee consisting of Medical Director, Administrator, DON, ADON, Risk Managemanet, MDS Coordinator, Medical Records, Social, Activities, Bookkeeping, Payroll, Food Service Supervisor, Maintenance and Environmental Services.	08/19/10

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F 279	Continued From page 5 BID (two times daily) and Remeron (anti depressant medication) 7.5 mg at HS (bedtime). Medical record review of the August 1 - 31, 2010, Recapitulation Orders revealed Seroquel 12.5 mg every morning, Seroquel 25 mg at bedtime, and Remeron 7.5 mg every bedtime for appetite. Review of the Minimum Data Set (MDS) dated May 5, 2010, and updated on August 5, 2010, revealed the resident received seven days of anti-psychotic medication and 7 days of anti-depressant medication. Review of the Resident Assessment Protocol dated May 11, 2010, revealed "Resident receives Remeron and Seroquel daily...will proceed to care plan." Review of the care plan dated May 11, 2010, and updated on August 6, 2010, revealed psychotropic medications had not been addressed. Interview with the MDS Nurse, on August 18, 2010, at 3:25 p.m., in the MDS office, confirmed the resident had received Seroquel and Remeron as ordered daily and the MDS for May 5, 2010, and August 5, 2010, addressed the seven days of psychotropic medication administration during the assessment period. Further interview confirmed the May 11, 2010, and August 6, 2010, care plans did not address the psychotropic medications. Resident #10 was admitted to the facility on February 9, 2005, with diagnoses including Alzheimer's Disease, Dementia with Atypical Psychosis, and Failure to Thrive. Further review revealed the resident was discharged to the hospital on July 26, 2010, and readmitted to the facility on August 9, 2010.	F 279		

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F 279	Continued From page 6 Medical record review revealed a physician phone order dated June 29, 2010, for hospice service assessment. Medical record review of the hospice documentation revealed the hospice effective date was June 29, 2010. Review of the care plan dated February 7, 2010, and updated on May 9, 2010, revealed the care plan was not updated to address the hospice service effective on June 29, 2010. Interview with LPN #1, on August 18, 2010, at 12:10 p.m., in the hall by the resident's room, confirmed a hospice Certified Nurse Aide came two times weekly to provide personal care and a hospice nurse came weekly to assess the resident. Interview with the MDS Nurse, on August 19, 2010, at 8:45 a.m., in the conference room, confirmed the resident was receiving hospice services since June 29, 2010, and the care plan was not updated to address the hospice services provided. Resident #2 was admitted to the facility on July 14, 2007, with diagnoses including Diabetes, Generalized Anxiety, Chronic Obstructive Pulmonary Disease, and Hypertension. Medical record review of the Minimum Data Set dated July 24, 2010, revealed the resident had short term memory deficit, moderately impaired decision making skills, was limited assist for ambulation. Medical record revealed the resident	F 279		

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F 279	Continued From page 7 had a history of falls and the fall risk assessment dated July 4, 2010, revealed was at a high risk. Medical record review revealed the resident had a fall on July 4, 2010, with no injuries. The new intervention was the resident was to have a wander guard. Review of the care plan updated July 27, 2010, revealed the intervention was not addressed. Interview with the ADON (Assistant Director of Nursing) on August 18, 2010, at 3:15 p.m., at the nurses' station, confirmed the care plan did not address the intervention of the wander guard.	F 279		
F 318	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure hand splints were applied for one (#2) of fifteen residents reviewed. The findings included: Resident #2 was admitted to the facility on July	F 318	D 318 SS=D Description 483.25(e)(2) Increase/ Prevent Decrease In Range of Motion The facility failed to ensure hand splints were applied on one resident. Corrective Action 1. Hand splints were applied to resident # 2 on 8/19/10 by restorative c.n.a. per OT recommendations and physician's orders. 2. DON, ADON, and Risk Management completed a facility audit to ensure that patients with splint orders had them applied. 3. Nursing and c.n.a. staff was in-serviced on 8/19/10 by DON regarding applying splints as ordered	

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F 318	Continued From page 8 14, 2007, with diagnoses including Diabetes, Generalized Anxiety, Chronic Obstructive Pulmonary Disease, and Hypertension. Medical record review of the Minimum Data Set dated July 24, 2010, revealed the resident had short term memory deficit, moderately impaired decision making skills, arm and hand had limitation on one side with partial loss. Medical record review of the physician's orders dated July 20, 2010, revealed "OT (occupational therapy) clarification order: pt. (patient) to receive r (right) hand splint to decrease pain and promote r (right) hand fine motor skills for ADL (activities of daily living)..." Observation of the resident on August 17, 2010, at 6:30 p.m., 8:35 p.m., August 18, 2010, at 7:30 a.m., 8:35 a.m., 9:50 a.m., in the resident's room, revealed the resident not wearing a splint on the right hand. Interview with the OTA (Occupational Therapy Assistant) and ADON (Assistant Director of Nursing) on August 18, 2010, at 3:05 p.m., in the therapy department, confirmed the right hand splint had not been applied.	F 318	4. DON, ADON and Risk Management will monitor for compliance during daily walking facility rounds. Findings will be reported to the QA Committee consisting of Medical Director, Administrator, DON, ADON, Risk Managemanet, MDS Coordinator, Medical Records, Social, Activities, Bookkeeping, Payroll, Food Service Supervisor, Maintenance and Environmental Services.	8/19/10